

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-023343

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

Primary Registration District No.

Registrar's No.

805

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILE 10-10-1963

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph,</b>		Length of stay in 1b <b>3 months</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Meth. Hosp. &amp; Med. Center</b>		d. STREET ADDRESS (If outside, give location) <b>509 Knickerbocker Place</b>	
3. NAME OF DECEASED (Type or print) First <b>OLIVIA</b> Middle <b>COLHOUN</b> Last <b>MOSS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1963</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1896</b>
9. AGE (last birthday) <b>66</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (City and state or country) <b>St. Joseph, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Louis Motter</b>		13b. MOTHER'S MAIDEN NAME <b>Olivia Colhoun</b>	
14. NAME OF HUSBAND OR WIFE <b>Preston L. Moss</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Preston L. Moss-Kansas City, Missouri</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lungs-metastatic 6 mos</b> <b>Carcinoma of Rt Breast 3 yrs</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>11:40</b> s.m. <b>PM</b> Month, Day, Year <b>Sept 19, 1963</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <b>St. Joseph, Missouri</b>	
21. I attended the deceased from <b>Sept 19, 1963</b> to <b>June 17, 1963</b> and last saw her alive on <b>June 17, 1963</b> Death occurred at <b>11:40 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22. SIGNATURE (Degree or title) <b>E.B. Thompson M.D.</b>	
22a. SIGNATURE		22b. ADDRESS <b>902 Edwards St. Joseph, Mo.</b>	
22c. DATE SIGNED <b>6/19/63</b>		23. NAME OF CEMETERY OR CREMATORY <b>Mt. Mora Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 20, 1963</b>	
23c. LOCATION (City, town, or county) <b>St. Joseph, Missouri</b>		24. FUNERAL DIRECTOR <b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>	
25. DATE RECD. BY LOCAL REG. <b>July 6, 1963</b>		26. REGISTRAR'S SIGNATURE <b>Mr. Clark Goodell</b>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF  
F.B. Thompson, M.D.

USE BLACK INK  
OR  
TYPEWRITER RIBBON

JUL 15 1963

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8488  
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Permit issued 6-19-63

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Charles E. Harrington

Licensed Embalmer No. 3258

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.